
Virginia Department of Mines, Minerals & Energy
Division of Mines

Accident Investigation Report
Underground Coal Mine

Electrocution Fatality
January 21, 2003

Dorchester Enterprises, Inc.
Mine No. 4
Mine Index No. 14698AA
Wise County, Virginia

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**Fatal Accident Scene
Dorchester Enterprises, Inc.
Mine No. 4
M.I. No. 14698AA**



**Coal/Water
Slurry**

**Standing
Water**

**Victim lying across
beam – head on
right side of beam**

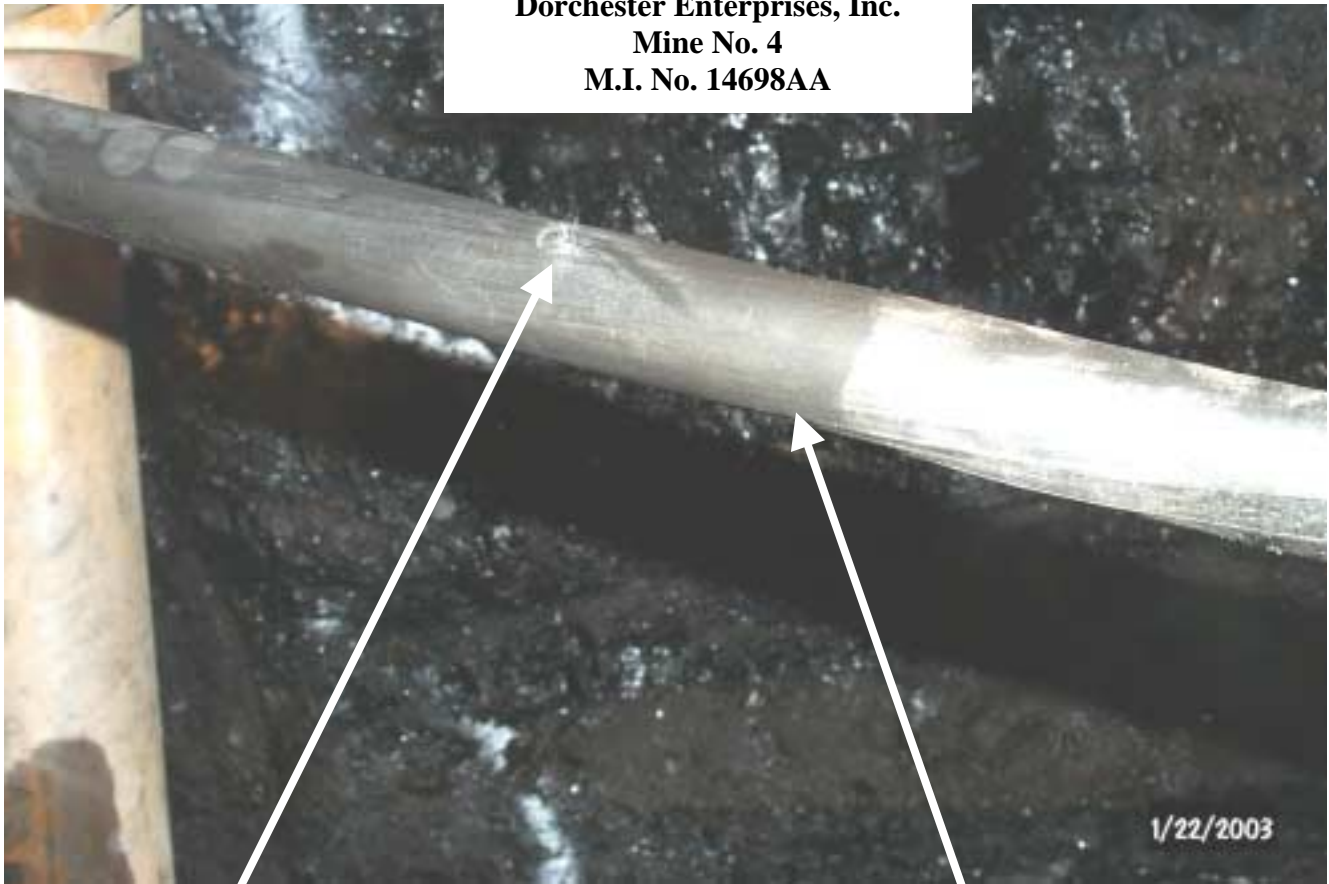
**Roof Bolting
Machine Cable**

**Steel beam with end cut -
found lying approx. 6”
from cable**



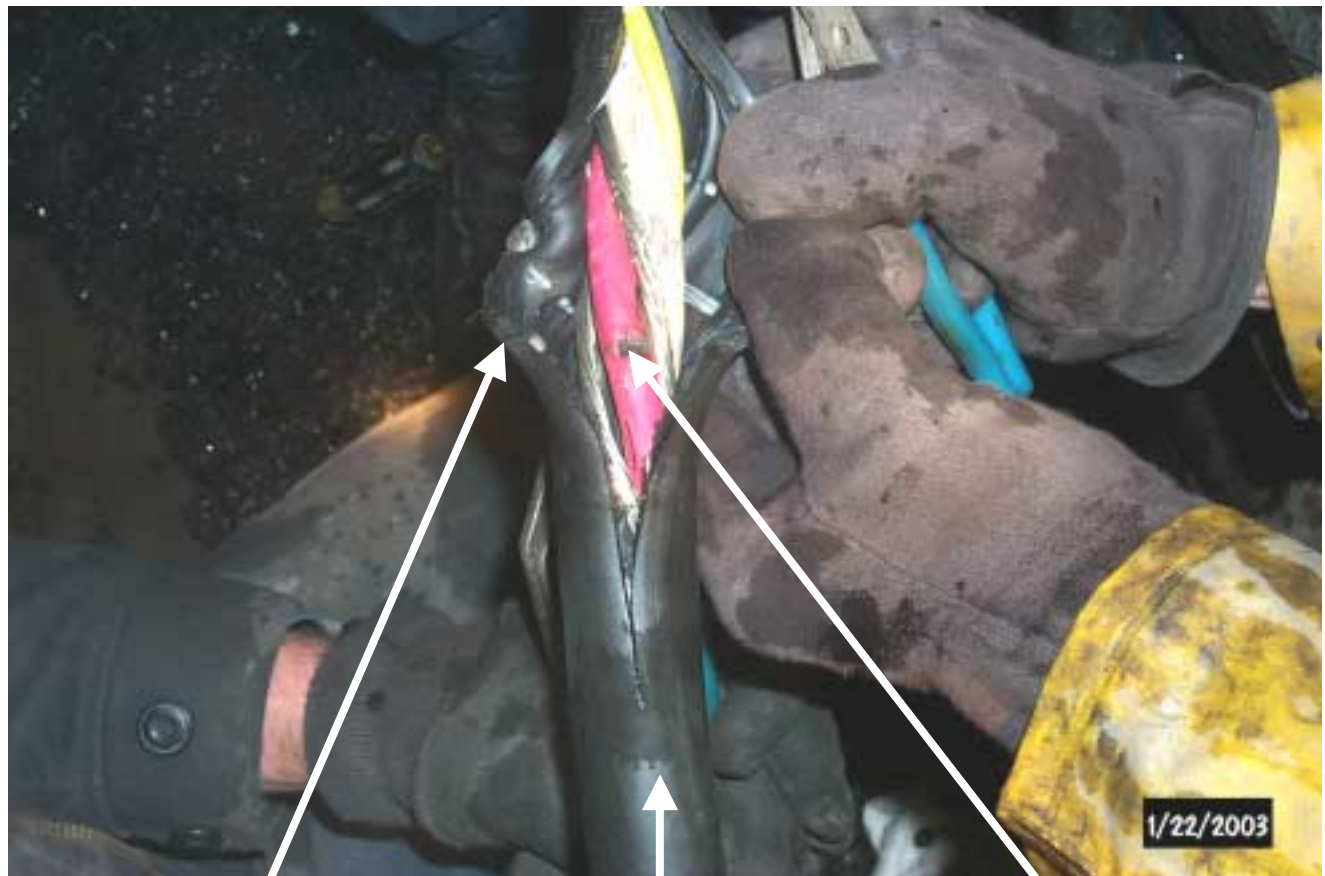
End of steel beam that had been cut with oxygen/acetylene torches – end of beam was observed lying approx. 6” from the damaged location on the roof bolting machine cable.

**Fatal Accident Scene
Dorchester Enterprises, Inc.
Mine No. 4
M.I. No. 14698AA**



Damaged Cable Insulation

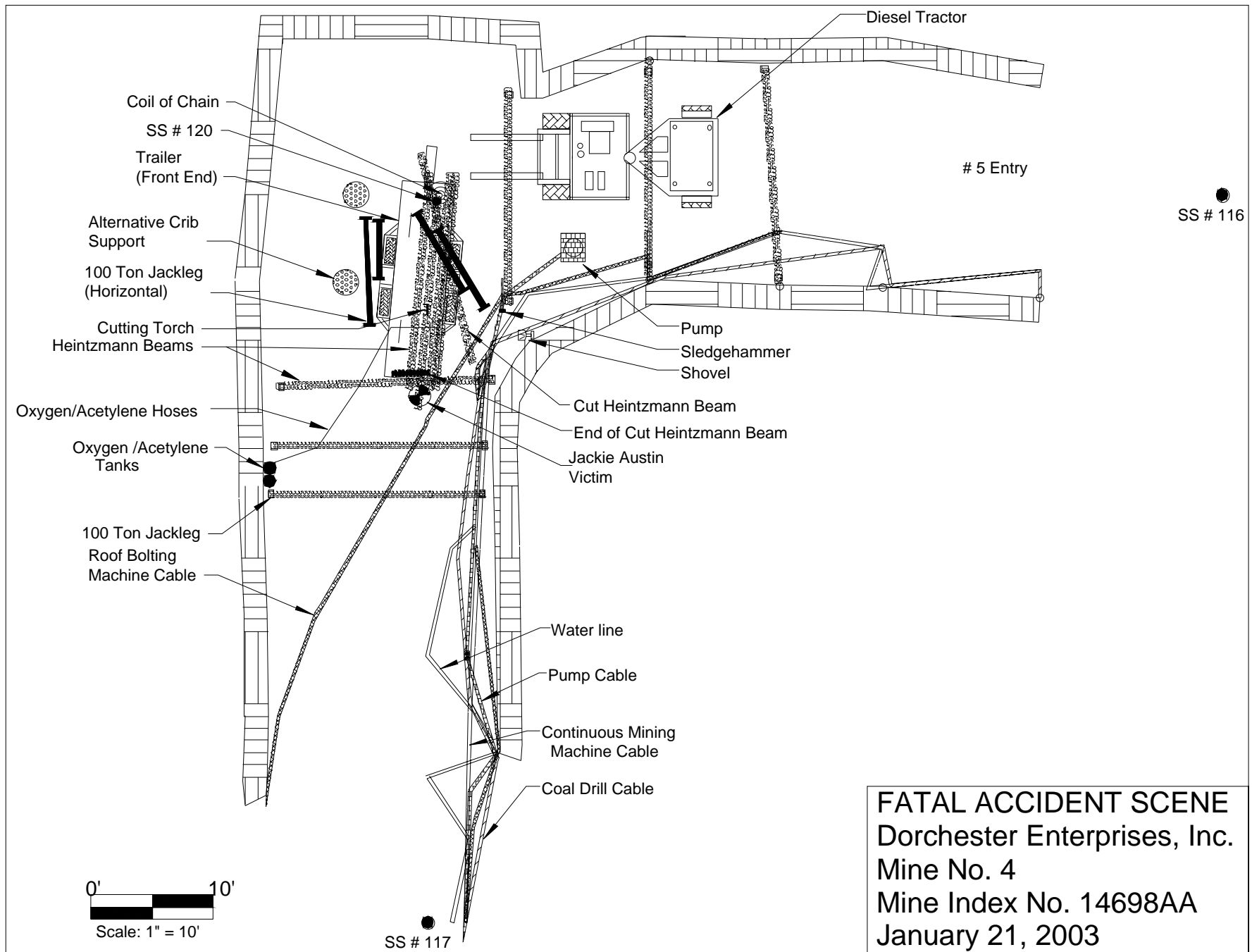
Roof Bolting Machine Cable



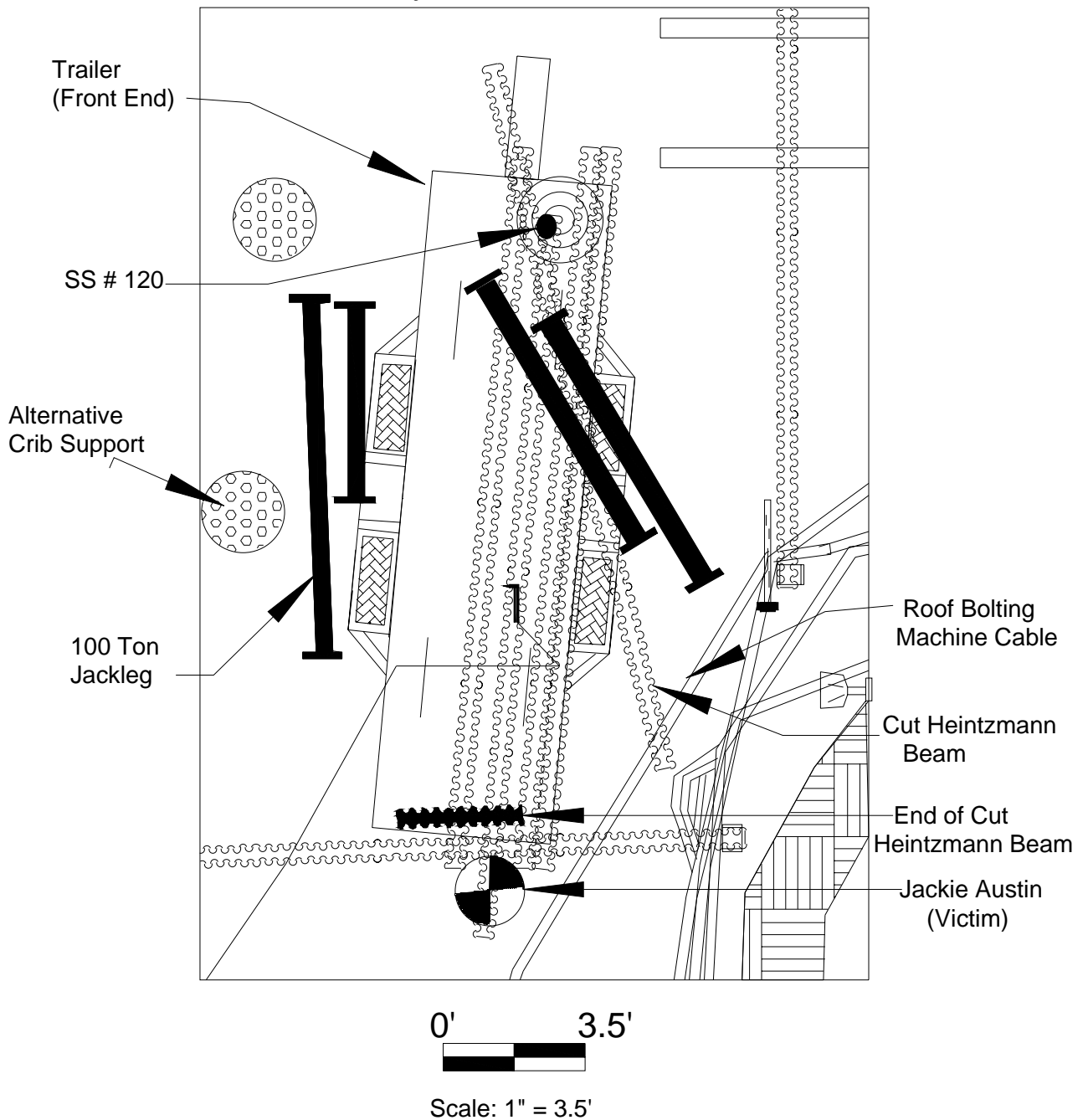
**Damaged cable insulation
area cut open for inspection**

**Roof bolting
machine cable**

**Damaged power
conductor insulation**



FATAL ACCIDENT SCENE
Dorchester Enterprises, Inc.
Mine No. 4
Mine Index No. 14698AA
January 21, 2003



ELECTROCUTION FATALITY INVESTIGATION REPORT
DORCHESTER ENTERPRISES, INC.
MINE NO. 4
MINE INDEX NO. 14698AA

On Tuesday, January 21, 2003, at approximately 1:55 p.m., an underground electrical power accident occurred at Dorchester Enterprises, Inc., Mine No. 4, Mine Index No. 14698AA. Jackie Lee Austin, general laborer, employed by The New Classic Company, Inc., was fatally injured when he apparently came in contact with a metal trailer and/or steel beams that had most likely become energized from a damaged 440 volt alternating current (AC) roof bolting machine trailing cable. Mr. Austin was transported to the surface and on to Wellmont Lonesome Pine Hospital in Big Stone Gap, VA, where he was pronounced dead at 2:51 p.m. by Dr. Kenneth Slater, emergency room physician. The State Medical Examiner's report of autopsy indicated low voltage electrocution as the cause of death. Mr. Austin was assisting coworkers installing Heintzmann steel beams as supplementary roof supports on the 001 Section. Mr. Austin, age 33, had two years total mining experience, with one year employment for The New Classic Company, Inc. The Department of Mines, Minerals and Energy's Division of Mines was notified of the accident at approximately 2:30 p.m. on January 21, 2003, and a joint investigation with the Federal Mine Safety and Health Administration was initiated the same day. The mine is scheduled to receive two regular inspections every six months. The last regular inspection had been completed on December 18, 2002.

COMMENTARY

Dorchester Enterprises, Inc., Mine No. 4, is located near Stonega, off State Route 78 North, in Wise County, Virginia. This underground mine is a one-section drift mine developed approximately 1,850 feet in the Imboden coal seam. Approximately 1,200 tons of raw coal are produced daily using continuous mining methods. Mining personnel produce coal on the first and third shifts with maintenance work performed on the second shift.

The New Classic Company, Inc., is an independent contracting company employed by Cumberland Resources Corporation to perform both underground and surface work at their mining operations located in Virginia and Kentucky. Dorchester Enterprises, Inc., Mine No. 4, is a subsidiary of Cumberland Resources Corporation. Mr. Austin and four other construction general laborers, employed by The New Classic Company, Inc., were performing underground work when the accident occurred.

On Tuesday, January 21, 2003, eleven mining personnel employed by Dorchester Enterprises, Inc., Mine No. 4, supervised by Mr. Michael Bowman, section mine foreman, arrived on the 001 section at approximately 7:30 a.m. to produce coal. The area where coal was being produced was located inby from where the accident occurred. Coal production proceeded normally during the shift until the accident occurred involving Mr. Austin. The construction general laborers entered the mine at approximately 7:15 a.m. under the direction of Mr. John Stewart, Jr., Contractor Supervisor. Mine management personnel had directed Mr. Stewart and

his employees to install Heintzmann steel beams as supplemental roof supports in the No. 5 entry, near survey station number 120, at areas identified by mine management personnel. These beams were transported on a four-wheel, rubber tire, metal trailer pulled by an A.L. Lee, Mini Trac II, diesel powered tractor. The beam installation process involved placing the beams against the mine roof with steel jacks installed underneath each end of the beams. Some beams were too long to be properly installed and were required to be cut with an oxygen/acetylene torch.

At approximately 12:15 p.m., Mr. Gail Kiser, General Mine Manager, arrived at the location where the steel beams were being installed. Mr. Kiser and Mr. Stewart were evaluating and discussing locations where additional roof supports would be installed. Mr. Stewart and the construction general laborers consisting of Mr. Austin, Mr. John Osborne, Mr. Jason Johnson and Mr. Samuel Sanders had installed five beams and were making preparations to install the sixth beam, at approximately 1:50 p.m.

The mine floor where the beams were being installed was wet, muddy and had standing water ranging from zero to eight inches in depth throughout the work area. Mr. Osborne had previously cut the metal legs to the proper length necessary to install the sixth beam. At this time, seven beams were lying in the metal trailer. Mr. Austin, Mr. Osborne, Mr. Johnson and Mr. Sanders positioned a beam diagonally across the top of the trailer with one end lying on the mine floor in preparation for cutting to the proper length. Mr. Osborne raised the end of the beam, supported it on one leg and cut approximately three feet off the beam and lowered this cut end onto the mine floor. Mr. Austin and Mr. Osborne, with assistance from Mr. Johnson and Mr. Sanders, planned to lift and install the cut beam onto the metal legs. Mr. Osborne walked around to the front of the trailer preparing to assist in lifting one end of the beam and expecting Mr. Austin to lift the cut end of the beam. Mr. Johnson walked around to the front of the trailer and touched a steel beam lying on the trailer a few seconds after the beam was cut and felt a “tingling” sensation of electricity and jerked back. Mr. Austin was holding the cut-off section of the beam that was later observed lying on the rear of the trailer during the investigation. Mr. Osborne walked to the front of the trailer and turned toward Mr. Sanders to ask for his assistance in lifting the beam when he heard Mr. Austin, located at the rear of the trailer, grunt twice and say “Oh God”. Then Mr. Osborne turned toward the rear of the trailer and saw Mr. Austin falling forward, face down, across the ends of the six beams that were extending from the rear of the trailer. Mr. Osborne ran down the outby side of the trailer and across the beam that had been cut to Mr. Austin’s location and touched him in an attempt to evaluate his condition. Mr. Osborne stated that he received an electrical shock when he touched Mr. Austin and jerked back, breaking contact with Mr. Austin. Then, Mr. Osborne stated that he said “boys, he’s getting electrocuted”. Mr. Osborne touched Mr. Austin a second time and received a second electrical shock. At this time, Mr. Kiser heard Mr. Osborne call for assistance and he ran by the front and down the outby side of the trailer and across the beam that had been cut to Mr. Austin’s location. Mr. Kiser, assisted by Mr. Osborne and Mr. Stewart, rolled Mr. Austin off the beams onto the mine floor. Mr. Osborne said that he felt a “tingle” of electricity, while Mr. Kiser and Mr. Stewart said that they didn’t feel any electricity as the three of them were rolling Mr. Austin off the beams onto the mine floor. Mr. Stewart conducted a patient assessment and determined that Mr. Austin was not breathing and had no pulse and he initiated cardiopulmonary resuscitation. Realizing that personnel with advanced first aid knowledge and skills were needed, Mr. Kiser

traveled to the 001 Section working places to summons Emergency Medical Technicians (EMT's) and Advanced First Aid certified personnel. Mr. Bowman and Mr. David Aistrop, certified as Emergency Medical Technician – First Responders and Mr. Bobby Wise, certified in Advanced First Aid, responded immediately to the accident scene and assisted Mr. Stewart and other mine personnel in administering cardiopulmonary resuscitation. Mr. Kiser instructed Mr. Sammy Stallard, electrical repairman, to go to the section mine telephone and to inform Mr. Frank Bowman, mine superintendent, located on the surface, of the accident and to request rescue squad assistance.

Mining personnel and Mr. Austin's coworkers continued cardiopulmonary resuscitation while they stabilized him on a spineboard. Cardiopulmonary resuscitation was continued while transporting Mr. Austin to the surface. Upon arrival on the surface, Appalachia Rescue Squad personnel assumed control and transported Mr. Austin to the Wellmont Lonesome Pine Hospital in Big Stone Gap, VA, where he was pronounced dead at 2:51 p.m. by Dr. Kenneth Slater, emergency room physician.

STATEMENTS FROM MINE PERSONNEL AND OTHER FACTORS:

Statements from mine personnel and other factors determined during the investigation revealed the following:

1. The accident occurred on January 21, 2003, at approximately 1:55 p.m. in the last open crosscut between No. 4 and No. 5 entries, approximately 18 feet from survey station number 120, located on the 001 Section.
2. Dorchester Enterprises, Inc., Mine No. 4, is a subsidiary of Cumberland Resources Corporation.
3. The New Classic Company, Inc. is an independent company contracted by Cumberland Resources Corporation to perform both underground and surface work at their mining operations located in Virginia and Kentucky.
4. The New Classic Company, Inc. employees including Mr. Stewart, Contractor Supervisor, and four construction general laborers had been instructed to install Heintzmann steel beams as supplemental roof supports in the face area of No. 5 entry near survey station number 120 on the 001 Section.
5. There were no eyewitnesses to the accident; however, four other construction co-workers and one Cumberland Resources Corporation employee were located in the general vicinity when the accident occurred.
6. Mr. Stewart and the construction general laborers had installed five steel beams and had prepared the sixth beam for installation when the accident occurred.
7. The construction general laborers positioned the sixth beam diagonally across the top of the metal trailer with one end lying on the mine floor. Mr. Austin and coworkers were

in direct contact with the beams and trailer while positioning the beam for cutting and none of them felt any sensation of electricity. Mr. Osborne stated that he cut three feet off the beam approximately 30 seconds before the accident occurred.

8. Mr. Osborne stated that after cutting the beam he walked to the front of the trailer to position himself to help lift one end of the beam into position for installation. Mr. Austin planned to lift the cut end of the beam.
9. Mr. Johnson stated that he walked around to the front of the trailer and touched a steel beam lying on the trailer a few seconds after the beam was cut, but before the accident occurred, and felt a “tingling” sensation of electricity and jerked back.
10. Mr. Osborne stated that Mr. Austin was holding the three-foot beam section that had been cut off and walked around to the rear of the trailer. During the investigation, this piece was observed lying on the rear of the trailer. No eyewitnesses saw Mr. Austin place the cut off section of steel beam on the trailer.
11. Mr. Osborne stated that he turned toward Mr. Sanders to ask for help in lifting the beam when he heard Mr. Austin, located at the rear of the trailer, grunt twice and say “Oh God”. At this time, Mr. Osborne ran to Mr. Austin’s location and touched him in an attempt to evaluate his condition. Mr. Osborne stated that he felt an electrical shock when he touched Mr. Austin. After feeling an electrical shock, Mr. Osborne broke contact with Mr. Austin. At this time, Mr. Osborne stated that he said “boys, he’s getting electrocuted”. Mr. Osborne stated that he touched Mr. Austin a second time and received a second electrical shock and again broke contact.
12. Mr. Osborne and Mr. Kiser stated that they ran down the outby side of the trailer and across the cut off end of the beam while traveling to Mr. Austin’s location when the accident occurred.
13. Mr. Osborne stated that he felt a “tingle” of electricity while Mr. Stewart and Mr. Kiser stated that they didn’t feel any electricity as the three of them were rolling Mr. Austin off the beams onto the mine floor. Mr. Stewart and Mr. Kiser stated that they were wearing rubber boots and Mr. Osborne stated that he was wearing leather boots and that his feet were wet.
14. Mr. Kiser, Mr. Stewart and Mr. Osborne’s recollection of the sequence of events differed, in that each stated that he was the first person to touch Mr. Austin after the accident.
15. Mr. Stewart stated that while assisting with cardiopulmonary resuscitation he observed a trailing cable in the immediate area where Mr. Austin was being treated. Mr. Stewart also observed the cut end of the beam lying over but not in direct contact with the trailing cable. This trailing cable was later identified as the 480 volt, three phase, alternating current power source for the section No. 1 roof bolting machine, and it was determined during the investigation that the cable was energized when the accident

occurred. Mine personnel also stated that they observed the cable underneath the beam approximately six inches from where the beam contacted the mine floor.

16. Mr. Kiser, Mr. Stewart and others stated that they did not feel any electricity while administering first aid and performing cardiopulmonary resuscitation on Mr. Austin.
17. Mr. Osborne stated that Mr. Austin was wearing leather boots and leather gloves with cloth gloves inserted inside the leather gloves. Mr. Osborne also stated that Mr. Austin had informed him, approximately 45 minutes before the accident occurred, that one of his boots was leaking and that one foot was wet.

PHYSICAL FACTORS

The investigation of physical factors revealed the following:

1. The electrical accident occurred in the No. 5 entry on the 001 section, approximately 18 feet from survey station number 120.
2. The mining height was seven feet and the entry width was nineteen feet and six inches where the accident occurred.
3. Coal/water slurry with some standing water, ranging from zero to eight inches in depth was present throughout the work area where the accident occurred.
4. A four wheel, rubber tire, metal trailer pulled by an A.L. Lee, Mini Trac II, diesel powered tractor was used to transport the steel beams to the 001 Section and was observed at the accident scene. The beams were 18 feet in length. The trailer is sixteen feet and four inches in length and four feet and six inches in width and is equipped with side rails that result in a total trailer height of 28 inches. Beams and jacks were observed lying on the trailer.
5. A section of steel beam, approximately three feet in length, identified as the piece that Mr. Austin was holding, was observed lying on the rear of the trailer.
6. Oxygen/acetylene tanks that were used to cut the steel beam were observed leaning against the inby rib near the trailer. The torches were observed lying in the trailer.
7. The beam that had been cut was observed lying partially on the trailer with the cut end lying against the mine floor in close proximity to but not touching the 480 volt, three phase, alternating current, No. 1 roof bolting machine trailing cable that was energized when the accident occurred. The cut end of the beam had a jagged edge with protruding slag that resulted from the cutting process. This cut end of the beam had been hot when placed on the mine floor in the immediate vicinity where the energized No. 1 roof bolting machine trailing cable was located.

8. The walkway clearance between the trailer and outby rib was limited due to the cut beam, installed jacks, section equipment trailing cables, waterline and a rock. Mr. Osborne and Mr. Kiser traveled through this partially obstructed area while enroute to Mr. Austin's location after the accident occurred.
9. The No. 1 roof bolting machine was located in the No. 4 entry inby the area where the accident occurred. A Number 2 American Wire Gauge (AWG), two kilovolt (KV) cable provided 480 volts alternating current (AC) to the machine and was routed through the last open crosscut between the No. 4 and No. 5 entries and down No. 5 entry to the section power center. This energized cable was observed at the rear of the trailer underneath the beam approximately six inches from where the beam contacted the mine floor. The top of the cable was barely visible in the area where the cut end of the beam contacted the mine floor due to accumulations of loose coal and water.
10. A damaged place on the energized 480-volt, No. 1 roof bolting machine trailing cable was observed in close proximity to but not touching the end of the beam that had been cut. The outer insulation of the trailing cable had been ruptured and physical damage had exposed the red phase conductor inside the cable. The damaged place on the cable was the most likely source of electricity that could have energized the metal trailer and beams.
11. On January 22, 2003, all circuit breakers, including the No. 1 roof bolting machine breaker located on the Line Power, 001 Section transformer, were examined and tested by grounding each phase supplied to each circuit breaker. All circuit breakers and ground check monitoring circuits operated properly. No circuit breakers tripped (de-energized) when the accident occurred indicating that none of the circuit breakers sensed a ground fault condition that would cause the breakers to trip (de-energize). A ground fault condition on the No. 1 roof bolting machine trailing cable could have existed during the accident and allowed sufficient current flow to cause the electrocution, but sufficient current was not available to activate the protective devices, thereby de-energizing the bolting machine circuit breaker.
12. All trailing cables providing power to section mining equipment were tested for both grounded phase and phase-to-phase conditions and no deficiencies were observed. All trailing cable couplers were examined and tested for proper grounding and no deficiencies were observed.
13. One circuit breaker located on the section power center provided power to a distribution box that was the power source for three underground pump circuits. The circuit breakers and ground check monitoring devices provided for the three pump circuits were examined and tested and all circuits operated properly.
14. The following observations, examinations and tests were conducted on the No. 1 roof bolting machine trailing cable:

- The cable was observed lying underneath but not in direct contact with the cut end of the beam;
- The beam was moved and placed on the trailer to gain access to thoroughly examine the cable in the immediate area where the cut end of the beam was observed during the investigation;
- The cable was lifted off the mine floor and secured to the mine roof with nylon ropes;
- A metal water clamp was placed around the cable approximately four feet from the area where the cut end of the beam crossed over the cable. The clamp was utilized to measure any potential voltage within the circumference of the cable;
- A Simpson 260 volt-ohm meter was utilized to measure any potential voltage by attaching one test lead to the metal water clamp and by placing the other test lead against the mine floor (earth);
- The volt-ohm meter was positioned on the alternating current (AC) function and the 50 volts range selector scale. A measurement of 50 volts was detected on the trailing cable outer jacket approximately two feet from the location where the cut end of the beam crossed over top of the energized trailing cable. A maximum of 50 volts can be detected with the meter set on the 50 volts range selector scale;
- The volt-ohm meter was then positioned on the alternating current (AC) function and the 250 volts range selector scale. A measurement of 250 volts was detected on the trailing cable outer jacket in the immediate area where the cut end of the beam crossed over top of the energized trailing cable;
- A small damaged place on the outer jacket of the trailing cable was identified as a result of 250 volts alternating current measured at this location;
- The trailing cable was cut open at the damaged location for further examination which revealed the extent of the damage extended from the outside to the inside of the cable jacket;
- A section of the trailing cable outer jacket was removed at the damaged place to evaluate the condition of the three phase power conductors. This examination revealed damage to the insulation provided for the red phase power conductor which had destroyed a small segment of insulation, exposing the phase conductor;
- Damage to the trailing cable's outer jacket and the red phase power conductor provided the electrical source from which 250 volts alternating current was measured on the outer jacket with the volt-ohm meter.
- A section of roof bolting machine trailing cable containing the damaged place was sent to the Federal Mine Safety and Health Administration's Approval and Certification Center located in Triadelphia, West Virginia, for testing. Mr. David Creamer, Chemist of the Materials and Explosions Testing Branch, examined and tested the section of damaged cable. Mr. Creamer concluded that the red phase power conductor insulation had been damaged by an external heat source.

CONCLUSION

On January 21, 2003, at approximately 1:55 p.m., an underground electrical power accident occurred at Dorchester Enterprises, Inc., Mine No. 4. Jackie Lee Austin, general laborer, employed by The New Classic Company, Inc., collapsed while performing underground construction work and was later pronounced dead at the Wellmont Lonesome Pine Hospital. The State Medical Examiner's report of autopsy indicated low voltage electrocution as the cause of death. Mr. Austin was fatally injured when he came in contact with a metal trailer and/or steel beams that had most likely become energized from a damaged 440 volt alternating current, roof bolting machine trailing cable. The Investigation Team considered the following in concluding that an electrocution occurred:

- The trailer used to transport the steel beams was moved into the area approximately two hours before the accident occurred. Mr. Austin and coworkers were in direct contact with the beams and trailer while positioning the beam for cutting immediately before the accident and none of them felt any electrical shock. The accident occurred at 1:55 p.m., approximately 30 to 60 seconds after the steel beam was cut. A direct relationship between cutting the beam, placing the cut end of the beam on the mine floor and the accident appears to exist. Mr. Johnson felt a sensation of electricity on the metal trailer/beams immediately after the beam was cut but a few seconds before the accident occurred. One event occurred that energized the trailer frame and a separate event occurred that removed the electrical energy from the trailer. The event that disrupted the flow of electricity from the trailer frame was most likely due to unintentional movement of the beam and/or cable after the accident occurred.
- A source of electricity was verified in the immediate area where the accident occurred that could have energized the metal trailer and beams providing sufficient voltage and current to have caused electrocution.
- The mine floor where the accident occurred was wet, muddy and had standing water ranging from zero to eight inches in depth throughout the work area.
- The State Medical Examiner's report of toxicological analysis did not indicate any abnormalities that contributed to Mr. Austin's death.
- Mr. Austin was wearing leather boots and he had informed Mr. Osborne that one boot was leaking and that one foot was wet approximately 45 minutes before the accident occurred. A wet, leather boot could have provided a low resistance path to ground potential for electricity to flow through Mr. Austin. Mr. Austin was wearing leather gloves with cloth gloves inserted inside the leather gloves.

ENFORCEMENT ACTION

The following enforcement action with Dorchester Enterprises, Inc., Mine No. 4, was taken as a result of the investigation:

1. An order of closure, No. FXL0002695, was issued under section 45.1-161.91.A.(ii) of the Coal Mine Safety Laws of Virginia to control and preserve the scene of the accident pending the investigation. The order of closure was modified to allow power circuits to be energized and normal mining operations to resume.
2. * A notice of violation, number FXL0002707, was issued under section 45.1-161.206 of the Coal Mine Safety Laws of Virginia. The investigation of the death of a miner was conducted by the Department of Mines, Minerals and Energy and the Federal Mine Safety and Health Administration on January 21 and 22, 2003, at Dorchester Enterprises, Inc., Mine No. 4. Mining personnel and/or independent contractor personnel stated in investigation interviews conducted on January 22, 2003, that an A.L. Lee, Mini-Trac II, non-permissible unit of diesel equipment, serial No. 01-1402, had been operated in the last row of open crosscuts between the No. 4 and No. 5 entries on the 001 section on January 21, 2003. This violation did not contribute to the fatal accident.
3. * A notice of violation, number FXL0002709, was issued under Section 45.1-161.207.B. of the Coal Mine Safety Laws of Virginia. The investigation of the death of a miner was conducted by the Department of Mines, Minerals and Energy and the Federal Mine Safety and Health Administration on January 21 and 22, 2003, at Dorchester Enterprises, Inc., Mine No. 4. Mining personnel and/or independent contractor personnel stated in investigation interviews conducted on January 22, 2003, that a test for methane gas had not been conducted prior to igniting oxygen/acetylene torches used to cut metal beams in the immediate area of survey station number 120 on the 001 section on January 21, 2003. This violation did not contribute to the fatal accident.
4. A notice of violation, number FXL 0002705, was issued under section 45.1-161.194.F. of the Coal Mine Safety Laws of Virginia. The investigation of the death of a miner was conducted by the Department of Mines, Minerals and Energy and the Federal Mine Safety and Health Administration on January 21 and 22, 2003, at Dorchester Enterprises, Inc., Mine No. 4. The trailing cable supplying power to the No. 1 Fletcher roof drill, Serial No. 20002-022, located on the 001 section in the immediate area of survey station number 120, was not protected against mechanical injury. On January 22, 2003, at approximately 9:35 a.m., a damaged place was detected in the trailing cable's outer jacket and the insulation provided for the red phase conductor. The damaged place observed on

the trailing cable and the red phase conductor insulation was located in the vicinity where the death of a miner had occurred on January 21, 2003, at approximately 1:55 p.m. At the location where the trailing cable was damaged, a Department of Mines, Minerals and Energy Technical Specialist/Electrical (certified electrical repairman), using a Simpson 260 volt-ohm meter, measured 250 volts alternating current between the outer jacket of the cable and the earth.

* Also issued to The New Classic Company, Inc.

RECOMMENDATIONS:

1. Recognize the potential hazards created when work activities are being conducted around electrical cables.
2. Trailing cables shall be protected against mechanical injury by hanging to the mine roof or by location to prevent damage from equipment or other work being performed in the affected area.
3. Miners should immediately de-energize power to any equipment or cable when stray electrical current is detected. This hazardous condition should be reported to the foreman and electrical repairman immediately.
4. Miners should wear rubber gloves when handling any type of energized low and medium voltage cables. Rubber boots provide additional protection and should be worn when practical.
5. The foreman and repairman should ensure that reports of damaged cables are checked and corrected immediately.

SIGNATURE SHEET

This report hereby submitted by Forrest Lambert, Jr. and approved by Frank A. Linkous:

FORREST LAMBERT, JR., COAL MINE INSPECTOR

Date

FRANK A. LINKOUS, CHIEF

Date

APPENDIX

- VICTIM DATA SHEET
- PERSONS PRESENT DURING THE INVESTIGATION
- MINE LICENSE INFORMATION

VICTIM DATA SHEET

Name:	Jackie Lee Austin
Occupation:	General Laborer
Mailing Address:	P. O. Box 1047, Castlewood, VA 24224
Date of Birth:	February 7, 1969
Total Mining Experience:	Two years
Experience with Present Company:	One year
Experience in Present Occupation:	One year

PERSONNEL

The following personnel provided information and/or were present during the investigation:

Dorchester Enterprises, Inc., Mine No. 4

Frank Bowman	Mine Superintendent
Michael Bowman	Section Mine Foreman
Bobby Wise, Jr.	Continuous Mining Machine Operator
Sammy Stallard	Electrical Repairman
David Aistrop	Shuttle Car Operator
Jeffrey Whisman	Chief Electrician

The New Classic Company, Inc.

John Brady Stewart, Jr.	Contractor Construction Supervisor
John Thomas Osborne	General Laborer
Jason Scott Johnson	General Laborer
Samuel Cleo Sanders	General Laborer

Cumberland Resources Corporation

Gail Kiser	General Mine Manager
Thomas Asbury	Safety Director

Cumberland Resources - Electrical Consultant

Hershel Bull

Federal Mine Safety and Health Administration

Benjamin S. Harding	Supervisory, Coal Mine Safety & Health Specialist, Ventilation
Russell A. Dresch	Electrical Engineer
Arnold D. Carico	Mining Engineer
Larry Meade, Jr.	Coal Mine Safety and Health Inspector
David Creamer	Chemist, Materials and Explosions Testing Branch– Approval and Certification Center

Virginia Department of Mines, Minerals and Energy
Division of Mines

John Thomas
Robert Garrett
Forrest Lambert, Jr.
Daniel Perkins

Mine Inspector Supervisor
Coal Mine Technical Specialist - Electrical
Coal Mine Inspector
Coal Mine Technical Specialist

Mine License Information

Official Corporation:	Dorchester Enterprises, Inc.
Official Business Name of Operator:	Dorchester Enterprises, Inc.
Person With Overall Responsibility:	Gail Kiser
Person in Charge of Health and Safety:	Gail Kiser